

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 001136	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/22/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LAKE PARK RESIDENTIAL CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RIPLEY ST LAKE STATION, IN 46405
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00188733.</p> <p>Complaint IN00188733- Substantiated. No deficiencies related to the allegation are cited.</p> <p>Survey date: December 22, 2015</p> <p>Facility number: 001136 Provider number: 001136 AIM number: N/A</p> <p>Census bed type: Residential: 125 Total: 125</p> <p>Census payor type: Other: 125 Total: 125</p> <p>Sample: 3</p> <p>Lake Park Residential Care was found to be in compliance with 410 IAC 16.2-5.1 in regard to the Investigation of Complaint IN00188733.</p> <p>Quality review completed by 26143, on December 23, 2015.</p>	R 000		

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------